BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation, First Supplemental Accusation, and Statement of Issues Against: VIRGINIA FRANCES DITTMEYER WALL Registered Nursing License No. 257146, Respondent.	Case No. 2004-107 OAH Nos: L2003120457 L2004120085

DECISION AFTER NONADOPTION

On May 2, 3 and 4, 2006, Deborah Myers, Administrative Law Judge, Office of Administrative Hearings, Los Angeles, State of California, heard these consolidated matters. Complainant, Ruth Ann Terry, was represented by Sharon Cohen, Deputy Attorney General. Respondent, Virginia Wall (Respondent), appeared and was represented by James Victor Kosnett, Attorney at Law.

Oral and documentary evidence was received. After a review of the exhibits, the parties stipulated to keep the record open for an undetermined period of time to allow the ALJ an indeterminate time period to issue the proposed decision. The record was subsequently closed and the matter was submitted for decision.

On September 1, 2006, the Administrative Law Judge issued her Proposed Decision in the matter. On September 19, 2006, the Board of Registered Nursing ("Board") issued its Notice of Non-Adoption of the Proposed Decision. On November 15, 2006, the Board issued its Request for Written Argument.

After review of the administrative record, including the transcript, exhibits, and written argument submitted by both parties, the Board hereby issues the following decision in this matter.

ISSUES

1. Whether Respondent committed acts of unprofessional conduct by falsifying or making grossly incorrect, inconsistent or unintelligible entries pertaining to controlled substances in hospital and patient records? (Alleged as the First Cause for Discipline and Denial of Application.)

2. Whether Respondent committed acts of unprofessional conduct by obtaining or possessing controlled substances in violation of law? (Alleged as the Second Cause for Discipline and Denial of Application.)

3. Whether Respondent committed acts of unprofessional conduct by diverting drugs from patients in need of pain medication and using controlled substances in a manner dangerous or injurious to persons, the public, or in such a way as to impair her ability to conduct the practice of nursing with safety to the public? (Alleged as the Third Cause for Discipline and Denial of Application.)

4. Whether Respondent committed gross negligence by committing extreme departures from the standard of care which a competent registered nurse would have used under similar circumstances? (Alleged as the Fourth Cause for Discipline and Denial of Application.)

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. The Accusation, First Supplemental Accusation, and Statement of Issues, were made by Ruth Ann Terry (Complainant), Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, State of California, (Board), acting in her official capacity.

2. On or about July 31, 1975, Respondent was originally licensed as a Registered Nurse under Registered Nursing License No. 257146. At all relevant times, the license was in full force and effect and will expire on July 31, 2007 unless renewed.

3. On November 20, 2003, the Board issued an Accusation against Respondent alleging that on October 6 and 8, 2002, as to five patients at Verdugo Hills Hospital, Respondent falsified or made grossly incorrect and inconsistent entries pertaining to controlled substances in hospital and patient records; obtained or possessed controlled substances in violation of law; diverted drugs from patients in need of pain medication and used them in a manner dangerous to persons; and committed extreme departures from the standard of care of a competent registered nurse.

4. The following amendments were stipulated to at the administrative hearing:

(A) Paragraph 13 of the Accusation was amended by identifying Patient # 26-93-26 as Patient Janet S. Paragraph 13b. was amended on lines 26 and 27 to read that "At 1900 hours Respondent documented in the nurse's patient medication profile that she administered one tablet of Vicodin.

(B) Paragraph 14 of the Accusation was amended by identifying Patient # 27-80-15 as Patient Mary P.

(C) Paragraph 15 of the Accusation was amended by identifying Patient # 06-90-00 as Patient Robert N.

(D) Paragraph 16 of the Accusation was amended by identifying Patient #08-03-23 as Patient Irene E.[1]

(E) Paragraph 17 of the Accusation was amended by identifying Patient #27-80-93 as Patient Philip C.

4. On September 19, 2005, the Board issued a First Supplemental Accusation against Respondent alleging that on or about March 9, 2005, as to one patient at Providence Holy Cross Hospital, Respondent falsified or made grossly incorrect entries in hospital and patient records. The following amendments were stipulated to at the administrative hearing:

(A) Paragraph 27 (a) of the First Supplemental Accusation was amended by identifying Patient #448659 as patient Doris V.

(B) Paragraph 27 (f) of the First Supplemental Accusation, line 28 was amended to read that "Respondent charted the administration of Demerol 75 mg. in the patient's MAR at 1850 hours, 10 minutes prior to signing out the medication."

5. On September 17, 2004, the Board issued a Statement of Issues against Respondent after receiving her application for a Public Health Certificate on August 16, 2004. The denial of her application and the resulting Statement of Issues alleged the same facts and causes for discipline as the Accusation. The following amendments were stipulated to at the administrative hearing:

(A) Paragraph 13 of the Statement of Issues was amended by identifying Patient # 26-93-26 as Patient Janet S.

(B) Paragraph 14 of the Statement of Issues was amended by identifying Patient # 27-80-15 as Patient Mary P.

(C) Paragraph 15 of the Statement of Issues was amended by identifying Patient # 06-90-00 as Patient Robert N.

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[1] This patient was originally identified by Complainant as Patient Janet E. This identification was erroneous and the record was later corrected.

(D) Paragraph 16 of the Statement of Issues was amended by identifying Patient #08-03-23 as Patient Irene E.[2]

(E) Paragraph 17 of the Statement of Issues was amended by identifying Patient #27-80-93 as Patient Philip C.

6. "Demerol" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(17). It is a narcotic analgesic and used for moderate to severe pain.

7. "Vicodin" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(j). It is a narcotic analgesic and used for moderate to severe pain.

8. "Visteril" is a dangerous drug pursuant to Health and Safety Code section 4022. It is an antihistamine and a sedative.

9. The expert witnesses called by the parties generally agreed on the standard of care that governs nurses making entries on patient records regarding administration of controlled substances. The evidence established that the standard of care requires accurate identification of the drug administered, the drug amount administered, and the manner in which it was administered. Charting must be done immediately after the drug is administered, in chronological order and contain no mistakes as to the amount signed out, wasted and administered. If charting is done late, then the entry must note it is a late entry. Charting must be legible.

10. The evidence established that the standard of care for a registered nurse in the withdrawal and disposal of controlled substances was to verify the correct drug, the correct time, the correct patient, the correct route, and the correct dose of the controlled substance. A registered nurse must sign out the controlled substance contemporaneously with the drug withdrawal in the controlled medication disposition record and verify the amount wasted by having another registered nurse witness the wastage. Both nurses must sign the controlled drug record sheet confirming the wastage. A registered nurse must chart the patient records right after administration. In the rare event that a registered nurse is extremely busy, the priority is to attend to the patient first and to the charting second.

11. The evidence established that the standard of care for a registered nurse in patient care during the administration of controlled substances is to give pain relief to patients within ½ hour of when the doctor prescribes the medication. If the doctor prescribes the medication pro re nata[3] (PRN), it is to be administered as

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2 This patient was originally identified by Complainant as Patient Janet E. This identification was erroneous and the record was later corrected.

3 An order that the medication be administered 'as needed.'

needed. A registered nurse must assess the level of patient pain, check their blood pressure, administer the medication, evaluate the patient pain to assess the effectiveness of the pain relief, and immediately chart her observations in the patient records.

12. The evidence established the standard of care for a registered nurse in administering medication was to do so only with a physician's orders. The registered nurse who initially reviews the physician orders must verify the drug dose, transcribe it into the patient PRN medication record and place his/her initials next to the drug entry. That patient's record is then referenced by any subsequent nurses who administer pain medication. All registered nurses must obtain clarification as to any doctor's orders or notations as to those medications if there are any irregularities, such the lack of the nurse's initials who transcribed the doctor's orders.

13. Complainant's and Respondent's experts also agree that as to six patients, on three separate days within two years, at two hospitals, Respondent made numerous charting errors. In committing these errors, Respondent acted below the standard of care.

14. On October 8, 2002, at Verdugo Hills Hospital, as to Patient Janet S., Respondent charted that she signed out 75 milligrams (mg.) of Demerol, administered 50 mg. and wasted 50 mg., which is mathematically incorrect. Her charting was sloppy. She did not chart right after she administered Demerol. Respondent charted in the patient medication profile that she administered one tablet of Vicodin but did not make any entries in the nurses' notes or the controlled drug record sheet. She did not chart that she performed a pain assessment. Each of these acts fell below the standard of care.

15. On October 8, 2002, at Verdugo Hills Hospital, as to Patient Mary P., Respondent did not chart that she performed a pain assessment for any PRN medication. She did not chart the administration of a total of 75 mg. of Demerol or 75 mg. of Vistiril. Respondent failed to have another registered nurse witness the wastage of 25 mg. of Demerol and wasted it in a manner that fell below the standard of care. Each of these acts fell below the standard of care.

16. On October 6, 2002, at Verdugo Hills Hospital, as to Patient Robert N., Respondent handled a controlled substance and charted that handling in a manner below the standard of care when she signed 50 mg of Demerol out of the pharmacy at 9:00 a.m. and charted she administered that Demerol at 8:00 a.m., one hour before. This was an improper time entry and poor charting. She failed to document a pain assessment and did not chart the administration of 50 mg. of Demerol. This was poor charting and fell below the standard of care.

17. On October 6, 2002, at Verdugo Hills Hospital, as to Patient Irene E., Respondent failed to chart in the patient's medication administration record the

administration of 50 mg. of Demerol and two Vicodin tablets. Instead, at the end of her shift, she charted that intra-muscular (IM) and per os[4] (PO) medication were given. Respondent administered this medication without doctor's orders. Each of these acts fell below the standard of care.

18. On October 6, 2002, at Verdugo Hills Hospital, as to Patient Philip C., Respondent failed to chart the administration of 50 mg. of Demerol in the patient's medication administration record or in the nurse's notes. She failed to document a pain assessment. This was poor charting and below the standard of care.

19. On March 9, 2005, at Providence Holy Cross Hospital, as to Patient Doris V., Respondent charted the withdrawal and administration of 6 doses of 75 mg. of Demerol over a nine hour period. Respondent only charted this administration on two lines as a "cumulative entry" at the end of her shift, stating she "medicated IM today for back and right shoulder pain with relief. Rates pain 8-9/10," filling only two lines. She wrote only seven lines of notes for a 12 hour shift. There was no doctor's orders for Demerol. Respondent relied on a PRN Medication Record entry for Demerol which lacked the transcribing nurse's initials: "Demerol 75. mg. IM q 3-4 hrs prn." While the standard of care is to rely on a PRN medication record notation, the standard of care is also to get clarification of a doctor's order if there is an irregularity. Respondent did not get clarification of that doctor's order and administered 6 doses of 75 mg. of Demerol over a nine hour period to an elderly patient, which fell below the standard of care. The evidence did not establish that Respondent wrote out the order on that record.

20. No credible evidence was presented to show that any patient in need of pain medication was deprived of the medication by Respondent's actions.

21. Complainant's expert, William Woodard, R.N. (Woodard), opined that Respondent's charting errors, her care of her patients, and her failure to follow hospital procedure taken together constituted an extreme departure from the standard of care and gross negligence.

22. Respondent's expert witness, Dr. Eleanor Kenney, BSN, MSN, Ph.D. (Kenney), disagreed with Woodard's characterization that Respondent's charting errors were an extreme departure from the standard of care and gross negligence. Kenney openly criticized Respondent's sloppy charting practices, her medication errors, her failure to chart blood pressure levels, her failure to chart whether patient relief was obtained, and her failure to get wastage witnessed. Kenney opined these acts were below the standard of care and demonstrated incompetence. Kenney also criticized Respondent's failure to get clarification on doctor's orders for Doris V., but did not say all six of those Demerol withdrawals were below the standard of care, as nurses are entitled to rely on transcriptions on the PRN records and to expect that

[4] Oral medication

those records are accurate. She based that opinion on her review of records and her observations.

23. Kenney opined that the existence and frequency of Respondent's charting mistakes were consistent with a busy nurse involved in many patient activities. She described Respondent's mistakes as indicative of two bad charting days while she was busy taking care of patients, which did not constitute a pattern of behavior. Kenney characterized Respondent's lack of documentation in the narrative notes about the administration of drugs to be sloppy charting and demonstrating incompetence. She opined that Respondent should have a restricted license until she passes required intensive classes in nursing such as nursing documentation, nursing refresher courses, orientation to the health care system.

24. However, Woodard's testimony is more persuasive regarding the departure from the standard of care. Dr. Kenney partially collaborated Woodard's testimony and did not satisfactorily explain why the number and degree of the deviations did not rise to the level of gross negligence. Respondent's charts include mathematical errors and time errors. The charts lack entries of pain assessments, blood pressure readings and dangerous drug administration. The charts show a failure to get Demerol wastage witnessed against hospital policy. They show a failure to verify a doctor's order and therefore improperly administer six doses of Demerol to an elderly patient in a nine hour period. These cumulative departures constitute an extreme departure from the standard of care.

25. Woodard initially opined Respondent falsified patient medication records in order to obtain and divert Demerol and Vicodin for her personal use. He believed that Respondent's charting errors of 225 mg of Demerol within two days on five patients exhibited a continual pattern of medication errors which an ordinarily prudent registered nurse would not have made. He further opined that Respondent's falsified patient medication records when she failed to obtain a witness signature after wasting 25 mg. of Demerol. He opined that these factors, along with her refusal to be interviewed and provide drug tests demonstrated a drug addiction. Woodard changed his conclusion when he learned that Respondent was instructed by her attorney to not be interviewed or provide drug tests, and concluded that under those circumstances, the charting errors were not indicative of a substance abuse problem.

26. Kenney opined that Respondent's charting errors were more consistent with sloppiness than diversion of drugs. Kenney opined the charting errors were more consistent with a nurse having so many activities that she was not able to get back to her charting. She even opined that on very rare occasions, nurses may be so busy that it could be difficult to have a witness during the wastage of medication. Kenney saw no evidence of diversion or falsification of records. Kenney did not believe that Respondent's 'two bad charting days' were indicative of drug diversion or drug use.

27. Woodard was a certified drug and rehabilitation counselor. He believed that a registered nurse who was abusing controlled substances would exhibit the following behaviors: an inability to concentrate, sleeplessness, mood swings, irritability, frequent trips to the bathroom, requests to work extra shifts, requests to stay late, failure to get co-signatures, patient complaints of pain, use of poor clinical judgment, more frequent errors, an overuse of PRN administration compared to her co-workers. He believed two patients complained of not getting pain medication, based on statements that a nurse made.

28. There was no competent evidence that Respondent displayed any of the physical symptoms of drug abuse during her shifts identified by Woodard, as set forth in Factual Finding 26. The evidence did not establish that Respondent diverted drugs for her own use. The evidence did not establish Respondent had physical possession of or was personally using Demerol or Vicodin during her shift. There was no evidence of vials, ampules, tourniquets, needles, or bloody rags in any of the staff bathrooms. While Respondent had a problem with Demerol approximately 25 years ago, that history is too remote upon which to base an inference of current misconduct and drug use.[5]

29. It was not established that Respondent falsified any patient records. Although the entries indicate many errors, it was not established that they were intentional to divert medication for her own use or otherwise.

30. The testimony of Dr. Eleanor Kenney is generally given considerable weight due to her superior educational and vocational qualifications. (Exhibit D). For almost 40 years, Dr. Kenney has lectured and instructed in bachelor's nursing programs at University of Southern California (USC) and California State University, Los Angeles (CSULA), and served as a clinical supervisor of RN, ADN and LVN programs at Pasadena Community College and Glendale Community College. Dr. Kenny has thirty years of clinical experience, including local hospitals in Los Angeles and Ventura counties. She also testified in a straightforward manner, even though it was contrary to Respondent's position. In light of Dr. Kenny's credible testimony and in the abundance of credible evidence in support of the allegations, it was not established that Respondent diverted any controlled substances.

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5 In December 1981, Respondent was confronted by her supervisor at Kaiser Hospital for going to the main floor bathroom frequently, being drowsy on duty, slurring speech, and being forgetful during assignments. The nursing staff reported this odd behavior, and discovered a bloody washcloth and tourniquet in the nurse's bathroom after Respondent had used it. Respondent had also charted the Demerol out on the narcotic record, but did not chart the patients' administration record. When confronted about her drug use, Respondent admitted to diverting Demerol and injecting it while on her shift to help with her depression. She immediately enrolled in a residential drug rehabilitation program. No action was taken to discipline Respondent's license.

31. Respondent testified in a soft spoken, almost slow and forgetful manner. She admitted making mistakes in charting but denied diverting the medication. She described herself being under a heavy workload and making some chart entries at the end of her shift. Respondent described her priority as patient care, charting second. Her memory was vague as to the entries she charted. She believed she forgot to make chart entries. Respondent believed she administered all six doses of Demerol to a patient, and believed there were doctor's orders for that Demerol. She admitted she made mistakes and her charting was deficient. Respondent was not aware of any patient harm.

32. When Respondent was asked whether she had her problem with Demerol under control, Respondent replied she didn't know how to answer that question. She denied she was addicted to any drugs, stated she was clean and sober since 1982 when she entered the Calabasas Hospital program. She completed the 12-step nurses' program in 1984. She provided seven clean drug tests from October 10, 2002 to April 24, 2006, and is willing to continue random testing. She is also willing to comply with any supervision and reporting requirements. Respondent loves her job as a registered nurse.

33. Respondent completed her Bachelor of Science in Nursing degree at California State University, Los Angeles (CSULA), in March, 2004, after almost eight years of study. Respondent provided numerous character reference letters from two nursing supervisors, a nurse, patients and their families, her own sister, and several long term friends. The supervisors' letters spoke highly of Respondent's expertise with ventilator-dependent patients, her trouble-shooting skills, her promptness, her organization, and her positive attitude. The patients' letters and other letters spoke of her compassion, her honesty, her patient advocacy, and her moral character. Her sister's letter denied any knowledge of drug relapse. Respondent seeks a Public Health Certificate because she believes it is the most important work she can do. She wants to treat people with diseases who wouldn't ordinarily receive health care.

34. The cost of investigation and prosecution in this case is $39,158.25. However, Complainant did not establish approximately half of the alleged causes for discipline and causes for denial. Moreover, one expert report contained a number of mathematical errors, and several witnesses testified it was not reliable. Those errors required their second expert witness to spend considerable time recalculating the figures and explaining the errors. Therefore, one-half, or $19,579.00 is considered to be reasonable. Complainant is entitled to recover those costs.

LEGAL CONCLUSIONS

Accusation:

1. Cause exists pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (e) to revoke or suspend Respondent's Registered Nurse license Number 257146 for making grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances, by reason of Factual Findings 6 through 24, inclusive. Respondent's repeated, frequent and cumulative errors over a three day period are extreme departures from the standard of care and gross negligence. Respondent's actions and medication placed many patients at risk of being inappropriately medicated with dangerous drugs.

2. Cause does not exist pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (a) to revoke or suspend Respondent's Registered Nurse license Number 257146 for having obtained or possessed controlled substances in violation of law, by reason of Factual Findings 6 through 32, inclusive. The evidence did not establish Respondent's poor charting amounted to drug possession or diversion.

3. Cause does not exist pursuant to Business and Professions Code section 2761, subdivision (a), and section 2762, subdivision (b) to revoke or suspend Respondent's Registered Nurse license Number 257146 for having diverted drugs from patients in need of pain medication and using controlled substances in a manner dangerous or injurious to persons, by reason of Factual Findings 6 through 32, inclusive. There was no competent evidence that Respondent diverted drugs and denied pain medication to any patients.

4. Cause exists pursuant to Business and Professions Code section 2761, subdivision (a)(1), to revoke or suspend Respondent's Registered Nurse license Number 257146 for having committed extreme departures from the standard of care of a competent registered nurse by reason of Factual Findings 6 through 24 and Legal Conclusion 1.

First Supplemental Accusation:

5. Cause exists pursuant to Business and Professions Code section 2761, subdivision (a), and section 2762, subdivision (e) to revoke or suspend Respondent's Registered Nurse license Number 257146 for having violated Health and Safety Code section 11173, subdivision (b) by making grossly incorrect, grossly inconsistent, or

unintelligible entries in hospital and patient records pertaining to controlled substances by reason of Factual Findings 6 through 24 and Legal Conclusion 1.

6. Cause does not exist pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (a) to revoke or suspend Respondent's Registered Nurse license Number 257146 for violating Health and Safety code section 11173, subdivision (a) by obtaining Demerol by fraud, deceit, or misrepresentation by reason of Factual Findings 6 through 32.

7. Pursuant to Business and Professions Code section 125.3, Complainant is entitled to recover the reasonable costs of investigation and prosecution of this case, which are $19,579.00, by reason of Factual Finding 34 and Legal Conclusions 1, 4, and 5.

Statement of Issues:

8. Cause exists pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (e) to deny Respondent's application for a Public Health Certificate for making grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances by reason of Factual Findings 6 through 24 and Legal Conclusion 1.

9. Cause does not exist pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (a) to deny Respondent's application for a Public Health Certificate for having obtained or possessed controlled substances in violation of law by reason of Factual Findings 6 through 32 and Legal Conclusion 2.

10. Cause does not exist pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (b) to deny Respondent's application for a Public Health Certificate for having diverted drugs from patients in need of pain medication and using controlled substances in a manner dangerous or injurious to persons by reason of Factual Findings 6 through 32 and Legal Conclusion 3.

11. Cause exists pursuant to Business and Professions Code section 2761, subdivision (a) and section 2762, subdivision (a)(1) to deny Respondent's application for a Public Health Certificate for having committed extreme departures from the standard of care of a competent registered nurse by reason of Factual Findings 6 through 24 and Legal Conclusion 4.

12. Based on respondent's prior problem with substance abuse and the recent problems with her practice as determined above, the Board believes that in order to public it is necessary that respondent be evaluated by a qualified health care professional to determine if she has a current substance abuse problem.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

A. Respondent's application for a Public Health Certificate is denied.

B. Respondent's Registered Nurse License Number 257146 is revoked. However, the revocation is stayed and respondent is placed on probation for three years on the following conditions.

1. Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

2. Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, Respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

3. If Respondent is under criminal court orders, including probation or parole, and the order is violated, this shall be deemed a violation of these probation conditions, and may result in the filing of an accusation and petition to revoke probation.

4. Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of Respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension. Upon successful completion of probation, respondent's license shall be fully restored.

5. Respondent, during the period of probation, shall appear in person at interviews/ meetings as directed by the Board or its designated representatives.

6. Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when she resides outside of California. Respondent must provide written notice to the Board within 15 days of any change of

residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

7. Respondent shall provide a list of all states and territories where he or she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

8. Respondent, during the period of probation, shall submit or cause to be submitted such written reports and declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to Respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

9. Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

10. Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

11. For purposes of compliance with condition number 10, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

12. The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

13. If Respondent has not complied with condition number 10 during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

14. Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse.

Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

15. Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

16. Respondent shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

17. Respondent shall obtain prior approval from the Board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

18. Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

19. Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours Respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with Respondent at least twice during each shift worked.

(d) Home Health Care - If Respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by respondent with or without respondent present.

20. Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

21. Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

22. Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict Respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

23. Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

24. Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

25. If Respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

26. Respondent, at her own expense, shall enroll and successfully complete all nursing refresher courses, orientation to health care system courses, and nursing documentation courses relevant to the practice of registered nursing recommended by the Board no later than six months prior to the end of her probationary term.

27. Respondent shall obtain prior approval from the Board before enrolling in the course(s) identified pursuant to condition number 26. Respondent shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to respondent after photocopying them for its records.

28. Within 45 days of the effective date of this decision, respondent, at her expense, shall have a licensed physician, nurse practitioner, or physician assistant, who is approved by the Board before the assessment is performed, submit an assessment to determine if Respondent has a substance abuse problem. Such an assessment shall be submitted in a format acceptable to the Board.

If the examiner conducting the physical health examination determines that the respondent is dependent upon drugs or alcohol, or has had problems with drugs or alcohol (i.e. drug dependence in remission or alcohol dependence in remission), that might reasonably affect the safe practice of nursing, then the respondent must further comply with the following additional terms and conditions of probation.

(A) PARTICIPATE IN TREATMENT/REHABILITATION PROGRAM FOR CHEMICAL DEPENDENCE - Respondent, at her expense, shall successfully complete during the probationary period or shall have successfully completed prior to commencement of probation a Board-approved treatment/rehabilitation program of at least six months duration. As required, reports shall be submitted by the program on forms provided by the Board. If respondent has not completed a Board-approved treatment/rehabilitation program prior to commencement of probation, respondent, within 45 days from the effective date of the decision, shall be enrolled in a program. If a program is not successfully completed within the first nine months of probation, the Board shall consider respondent in violation of probation.

Based on Board recommendation, each week respondent shall be required to attend at least one, but no more than five 12-step recovery meetings or equivalent (e.g., Narcotics Anonymous, Alcoholics Anonymous, etc.) and a nurse support group as approved and directed by the Board. If a nurse support group is not available, an additional 12-step meeting or equivalent shall be added. Respondent shall submit dated and signed documentation confirming such attendance to the Board during the entire period of probation. Respondent shall continue with the recovery plan recommended by the treatment/rehabilitation program or a licensed mental health examiner and/or other ongoing recovery groups.

(B) ABSTAIN FROM USE OF PSYCHOTROPIC (MOOD-ALTERING) DRUGS - Respondent shall completely abstain from the possession, injection or consumption by any route of all psychotropic (mood altering) drugs, including alcohol, except when the same are ordered by a health care professional legally authorized to do so as part of documented medical treatment. Respondent shall have sent to the Board, in writing and within fourteen (14) days, by the prescribing health professional, a report identifying the medication, dosage, the date the medication was prescribed, the respondent's prognosis, the date the medication will no longer be required, and the effect on the recovery plan, if appropriate.

Respondent shall identify for the Board a single physician, nurse practitioner or physician assistant who shall be aware of respondent's history of substance abuse and will coordinate and monitor any prescriptions for respondent for dangerous drugs, controlled substances or mood-altering drugs. The coordinating physician, nurse practitioner, or physician assistant shall report to the Board on a quarterly basis respondent's compliance with this condition. If any substances considered addictive have been prescribed, the report shall identify a program for the time limited use of any such substances.

The Board may require the single coordinating physician, nurse practitioner, or physician assistant to be a specialist in addictive medicine, or to consult with a specialist in addictive medicine.

(C) SUBMIT TO TESTS AND SAMPLES - Respondent, at her expense, shall participate in a random, biological fluid testing or a drug screening program which the Board approves. The length of time and frequency will be subject to approval by the Board. The respondent is responsible for keeping the Board informed of respondent's current telephone number at all times. Respondent shall also ensure that messages may be left at the telephone number when she is not available and ensure that reports are submitted directly by the testing agency to the Board, as directed. Any confirmed positive finding shall be reported immediately to the Board by the program and the respondent shall be considered in violation of probation.

In addition, respondent, at any time during the period of probation, shall fully cooperate with the Board or any of its representatives, and shall, when requested, submit to such tests and samples as the Board or its representatives may require for the detection of alcohol, narcotics, hypnotics, dangerous drugs, or other controlled substances.

If respondent has a positive drug screen for any substance not legally authorized and not reported to the coordinating physician, nurse practitioner, or physician assistant, and the Board files a petition to revoke probation or an accusation, the Board may suspend respondent from practice pending the final decision on the petition to revoke probation or the accusation. This period of suspension will not apply to the reduction of this probationary time period.

If respondent fails to participate in a random, biological fluid testing or drug screening program within the specified time frame, the respondent shall immediately cease practice and shall not resume practice until notified by the Board. After taking into account documented evidence of mitigation, if the Board files a petition to revoke probation or an accusation, the Board may suspend respondent from practice pending the final decision on the petition to revoke probation or the accusation. This period of suspension will not apply to the reduction of this probationary time period.

(D) THERAPY OR COUNSELING PROGRAM - Respondent, at her expense, shall participate in an on-going counseling program until such time as the Board releases her from this requirement and only upon the recommendation of the counselor. Written progress reports from the counselor will be required at various intervals.

29. Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $19,579.00. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

30. If Respondent has not complied with condition number 29 during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation will apply.

31. If Respondent violates the conditions of her probation, the Board after giving Respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline of revocation of Respondent's license.

32. If during the period of probation, an accusation or petition to revoke probation has been filed against Respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against Respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

33. During Respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, Respondent may surrender her license to the Board. The Board reserves the right to

evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, Respondent will no longer be subject to the conditions of probation.

34. Surrender of Respondent's license shall be considered a disciplinary action and shall become a part of Respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(1) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

(2) One year for a license surrendered for a mental or physical illness.

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C. Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $19,579.00. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

IT IS SO ORDERED.

The effective date of this decision is APRIL 8, 2007

Dated: MARCH 8, 2007

LAFRANCINE TATE
BOARD OF REGISTERED NURSING
STATE OF CALIFORNIA

BILL LOCKYER, Attorney General
of the State of California
SHARON F. COHEN, R.N., State Bar No. 107140
Supervising Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2533
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: VIRGINIA FRANCIS DITTMYER WALL 10517 Lanark Street Sun Valley, CA 91352 Registered Nursing License No. 257146, Respondent.	Case No. 2004-107 OAH No. L-2003120457 **FIRST SUPPLEMENTAL ACCUSATION**

Ruth Ann Terry, M.P. H., R.N., for further causes for discipline alleges:

PARTIES

22. Complainant Ruth Ann Terry, M.P.H., R.N., makes and files this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

23. On or about July 31, 1975, the Board of Registered Nursing issued Registered Nursing License No. 257146 to Virginia Francis Dittmyer Wall (Respondent). The Registered Nursing license was in full force and effect at all times relevant herein and will expire on July 31, 2007, if not renewed.

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JURISDICTION

24. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

25. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

26. Section 11173 of the Health and Safety Code states:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

"(b) No person shall make a false statement in any prescription, order, report, or record, required by the division."

FIRST CAUSE FOR DISCIPLINE

(Falsified Hospital Records)

27. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code on the grounds of unprofessional conduct as defined in section 2762, subdivision (e), for violating section 11173, subdivision (b) of the Health and Safety Code, in that while on duty as a registered nurse at Providence Holy Cross Medical Center in Mission Hills, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital and patient records pertaining to controlled substances and dangerous drugs in the following respects:

Patient # 448659

a. On or about March 9, 2005, at 0800 hours, Respondent signed out Demerol 75mg. on the 24-hour Controlled Medication Disposition Record (CMDR), for patient

#448659 and documented the administration of the medication in the pharmacy record sheet at 0800 hours. Respondent charted the administration of Demerol 75mg in the patient's MAR at 0730 hours, one-half hour prior to signing out the medication. There were no physician orders for Demerol 75mg. for this patient.

b. On or about March 9, 2005, at 1000 hours, Respondent signed out Demerol 75mg on the CMDR for patient #448659. Respondent documented the administration of the medication in the pharmacy record sheet and charted the administration of Demerol 75mg. in the patient's MAR at 1000 hours. There were no physician orders for Demerol 75mg. for this patient.

c. On or about March 9, 2005, at 1300 hours, Respondent signed out Demerol 75mg. on the CMDR for patient #448659 and documented the administration of the medication in the pharmacy record sheet at 1300 hours. Respondent failed to chart the administration of Demerol 75mg. in the patient's MAR and failed to record wastage or otherwise account for Demerol 75mg. There were no physician orders for Demerol 75mg. for this patient.

d. On or about March 9, 2005, at 1330 hours, Respondent signed out Demerol 75mg. on the CMDR for patient #448659 and documented the administration of the medication in the pharmacy record sheet at 1330 hours. Respondent failed to chart the administration of Demerol 75mg. in the patient's MAR and failed to record wastage or otherwise account for Demerol 75mg. There were no physician orders for Demerol 75mg. for this patient.

e. On or about March 9, 2005, at 1600 hours, Respondent signed out Demerol 75mg. on the CMDR for patient #448659 and documented the administration of the medication in the pharmacy record sheet at 1600 hours. Respondent charted the administration of Demerol 75mg in the patient's MAR at 1500 hours, one hour prior to signing out the medication. There were no physician orders for Demerol 75mg. for this patient.

f. On or about March 9, 2005, at 1900 hours, Respondent signed out Demerol 75mg. on the CMDR for patient #448659 and documented the administration of the medication in the pharmacy record sheet at 1900 hours. Respondent charted the administration of Demerol 75mg. in the patient's MAR at 1850 hours, one-half hour prior to signing out the

medication. There were no physician orders for Demerol 75mg. for this patient.

g. On or about March 8, 2005, Respondent wrote an order on patient #449659's medication record for "Demerol 75mg. IM q 3-4 hrs prn." There was no physician's order for Demerol 75 IM to substantiate this entry.

SECOND CAUSE FOR DISCIPLINE

(Obtained Or Possessed Controlled Substance by Fraud or Deceit)

28. Respondent is subject to disciplinary action under section 2761, subdivision (a), of the Code on the grounds of unprofessional conduct as defined in section 2762, subdivision (a) for violating Health and Safety Code section 11173, subdivision (a), in that while on duty as a registered nurse at Providence Holy Cross Medical Center, Respondent obtained Demerol, a controlled substance, by fraud, deceit, misrepresentation or subterfuge, as more fully set forth in paragraph 28, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License No. 257146, issued to Virginia Francis Dittmyer Wall.

2. Ordering Virginia Francis Dittmyer Wall to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/19/05

RUTH ANN TERRY, M.P.H., R.N
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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CML (08/30/2005)

BILL LOCKYER, Attorney General
of the State of California
ALAN A. MANGELS, State Bar No. 57690
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2554
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: VIRGINIA FRANCES DITTMYER WALL 10517 Lanark Street Sun Valley, CA 91352 Registered Nurse License No. 257146 Respondent.	Case No. 2004 - 107 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant), brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), California Department of Consumer Affairs.

2. On or about July 31, 1975, the Board of Registered Nursing issued Registered Nurse License Number 257146 to Virginia Frances Dittmyer, currently known as Virginia Frances Dittmyer Wall (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2005, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 provides that the Board may discipline any licensee, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761(a) of the Code states that the board may take disciplinary action against a certified or licensed nurse for unprofessional conduct, which includes, but is not limited to:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

6. Section 2762 provides that it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to herself, or furnish or administer to another, any controlled substance or any dangerous drug.

(b) Use any controlled substance or dangerous drug to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impairs her ability to conduct with safety to the public the practice authorized by her license.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

7. Section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

8. California Code of Regulations, title 16, section 1442, states that gross negligence includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

DRUGS

9. "Demerol," a brand of meperidine hydrochloride, is a derivative of pethidine and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(17). It is a narcotic analgesic used for moderate to severe pain.

10. "Vicodin," a brand of hydrocodone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(j). It is a narcotic analgesic for moderate to moderately severe pain.

11. "Vistaril," a brand of hydroxyzine hydrochloride, is a dangerous drug pursuant to Section 4022. It is an antihistamine and sedative.

FACTUAL SUMMARY

12. During a period including May - October, 2002, Respondent diverted controlled substances while working as a registered nurse at Verdugo Hills Hospital, including the following:

13. **Patient #26-93-26** - October 8, 2002

a. At 1800 hours, Respondent signed 75mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 50mg. Respondent documented in the patient's Medication Administration Record that she administered 50mg of Demerol and 25mg of Vistaril.

b. At 1900 hours Respondent documented in the nurse's notes that she administered one tablet of Vicodin. No corresponding entry was made in the nurse's notes or the Controlled Drug Record Sheet.

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14. **Patient #27-80-15** - October 8, 2002

a. At 0800 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg. Respondent documented in the patient's Medication Administration Record that she administered 25mg of Demerol and 25mg of Vistaril. No corresponding entry was made in the nurse's notes.

b. At or around 1000 or 1100 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg. At 1100 hours, Respondent documented in the patient's Medication Administration Record that she administered 25mg of Demerol and 25mg of Vistaril. No corresponding entry was made in the nurse's notes.

c. At 1300 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg, however, this was not witnessed. Respondent failed to document or otherwise account for the remaining 25mg. At 1500 hours, Respondent documented in the patient's Medication Administration Record that she administered 25mg of Demerol and 25mg of Vistaril. No corresponding entry was made in the nurse's notes.

d. At 1700 hours, Respondent signed 75mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg. Respondent documented that she administered 25mg but failed to account for the remaining 25mg.

15. **Patient #06-90-00** - October 6, 2002

a. At 0800 hours, Respondent documented that she administered 50mg of Demerol in the patient's Medication Administration Record. No corresponding entry was made in the nurse's notes. At 0900 hours, Respondent signed 50mg of Demerol out of the narcotic drawer.

b. At 1200 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she administered 50mg of Demerol in the

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patient's Medication Administration Record. No corresponding entry was made in the nurse's notes.

16. **Patient #08-03-23** - October 6, 2002

a. The attending physician prescribed Motrin and Vicodin but did not prescribe Demerol for this patient. At 1730 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent failed to document the disposition of the medication in the patient's Medication Administration Record.

b. At 1830 hours, Respondent signed 2 tabs of Vicodin out of the narcotic drawer. Respondent failed to document the disposition of the medication in the patient's Medication Administration Record.

17. **Patient #27-80-93** - October 6, 2002

a. At 1730 hours, Respondent signed 100mg of Demerol out of the narcotic drawer. Respondent failed to document the disposition of the medication in the patient's Medication Administration Record or nurse's notes.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - False Records)

18. Respondent is subject to disciplinary action pursuant to Section 2761(a) for unprofessional conduct as defined by Section 2762(e) in that Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances as stated in paragraphs 12 - 17.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Controlled Substances)

19. Respondent is subject to disciplinary action pursuant to Section 2761(a) for unprofessional conduct as defined by Section 2762(a) in that Respondent obtained or possessed controlled substances in violation of law as stated in paragraphs 12 - 17.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Use of a Controlled Substance)

20. Respondent is subject to disciplinary action pursuant to Section 2761(a)

for unprofessional conduct as defined by Section 2762(b) by diverting drugs from patients in need of pain medication, she used controlled substances in a manner dangerous or injurious to persons, or the public or to the extent that such use impaired her ability to conduct the practice of nursing with safety to the public as stated in paragraphs 12 - 17.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action pursuant to Section 2761(a)(1) for gross negligence in that Respondent committed extreme departures from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse, as stated in paragraphs 12 - 17.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 257146, issued to Virginia Frances Dittmyer Wall;

2. Ordering Virginia Frances Dittmyer Wall to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/20/03

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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BILL LOCKYER, Attorney General
of the State of California
LORRIE M. YOST, State Bar No. 119088
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2562
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against: VIRGINIA FRANCES DITTMYER WALL 10517 Lanark Street Sun Valley, CA 91352 Respondent.	Case No. 2004-107 OAH No. L-2003120457 **STATEMENT OF ISSUES**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant), brings this Statement of Issues solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), California Department of Consumer Affairs.

2. On or about July 31, 1975, the Board of Registered Nursing issued Registered Nurse License Number 257146 to Virginia Frances Dittmyer, currently known as Virginia Frances Dittmyer Wall (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2005,

3. On or about August 16, 2004, the Board of Registered Nursing, Department of Consumer Affairs received an application for a Public Health Certificate from Virginia Frances Wall. On or about August 3, 2004, Virginia Wall certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application.

JURISDICTION

4. This Statement of Issues is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

5. Section 2736 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may deny a license when it finds that the applicant has committed any acts constituting grounds for denial of licensure under section 480 of that Code.

6. Section 480 of the Code states in pertinent part:

"(a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

. . . .

"(3) Done any act which if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

"The board may deny a license pursuant to this subdivision only if the crime or act is substantially related to the qualifications, functions or duties of the business or profession for which application is made.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

8. Section 2762 provides that it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to herself, or furnish or administer to another, any controlled substance or any dangerous drug.

(b) Use any controlled substance or dangerous drug to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impairs her ability to conduct with safety to the public the practice authorized by her license.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

DRUGS

9. "Demerol," a brand of meperidine hydrochloride, is a derivative of pethidine and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(17). It is a narcotic analgesic used for moderate to severe pain.

10. "Vicodin," a brand of hydrocodone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(j). It is a narcotic analgesic for moderate to moderately severe pain.

11. "Vistaril," a brand of hydroxyzine hydrochloride, is a dangerous drug pursuant to Section 4022. It is an antihistamine and sedative.

FACTUAL SUMMARY

12. During a period including May - October, 2002, Respondent diverted controlled substances while working as a registered nurse at Verdugo Hills Hospital, including the following:

13. **Patient #26-93-26** - October 8, 2002

a. At 1800 hours, Respondent signed 75mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 50mg. Respondent documented

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in the patient's Medication Administration Record that she administered 50mg of Demerol and 25mg of Vistaril.

b. At 1900 hours Respondent documented in the nurse's notes that she administered one tablet of Vicodin. No corresponding entry was made in the nurse's notes or the Controlled Drug Record Sheet.

14. **Patient #27-80-15** - October 8, 2002

a. At 0800 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg. Respondent documented in the patient's Medication Administration Record that she administered 25mg of Demerol and 25mg of Vistaril. No corresponding entry was made in the nurse's notes.

b. At or around 1000 or 1100 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg. At 1100 hours, Respondent documented in the patient's Medication Administration Record that she administered 25mg of Demerol and 25mg of Vistaril. No corresponding entry was made in the nurse's notes.

c. At 1300 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg, however, this was not witnessed. Respondent failed to document or otherwise account for the remaining 25mg. At 1500 hours, Respondent documented in the patient's Medication Administration Record that she administered 25mg of Demerol and 25mg of Vistaril. No corresponding entry was made in the nurse's notes.

d. At 1700 hours, Respondent signed 75mg of Demerol out of the narcotic drawer. Respondent documented that she wasted 25mg. Respondent documented that she administered 25mg but failed to account for the remaining 25mg.

15. **Patient #06-90-00** - October 6, 2002

a. At 0800 hours, Respondent documented that she administered 50mg of Demerol in the patient's Medication Administration Record. No corresponding entry

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was made in the nurse's notes. At 0900 hours, Respondent signed 50mg of Demerol out of the narcotic drawer.

b. At 1200 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent documented that she administered 50mg of Demerol in the patient's Medication Administration Record. No corresponding entry was made in the nurse's notes.

16. **Patient #08-03-23** - October 6, 2002

a. The attending physician prescribed Motrin and Vicodin but did not prescribe Demerol for this patient. At 1730 hours, Respondent signed 50mg of Demerol out of the narcotic drawer. Respondent failed to document the disposition of the medication in the patient's Medication Administration Record.

b. At 1830 hours, Respondent signed 2 tabs of Vicodin out of the narcotic drawer. Respondent failed to document the disposition of the medication in the patient's Medication Administration Record.

17. **Patient #27-80-93** - October 6, 2002

a. At 1730 hours, Respondent signed 100mg of Demerol out of the narcotic drawer. Respondent failed to document the disposition of the medication in the patient's Medication Administration Record or nurse's notes.

FIRST CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct - False Records)

18. Respondent's application is subject to denial under Section 2761(a) for unprofessional conduct as defined by Section 2762(e) in that Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances as stated in paragraphs 12 - 17.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Controlled Substances)

19. Respondent's application is subject to denial under Section 2761(a) for unprofessional conduct as defined by Section 2762(a) in that Respondent obtained or possessed controlled substances in violation of law as stated in paragraphs 12 - 17.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Use of a Controlled Substance)

20. Respondent's application is subject to denial under Section 2761(a) for unprofessional conduct as defined by Section 2762(b) by diverting drugs from patients in need of pain medication, she used controlled substances in a manner dangerous or injurious to persons, or the public or to the extent that such use impaired her ability to conduct the practice of nursing with safety to the public as stated in paragraphs 12 - 17.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent's application is subject to denial under Section 2761(a)(1) for gross negligence in that Respondent committed extreme departures from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse, as stated in paragraphs 12 - 17.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Denying the application of Virginia Frances Wall a.k.a. Virginia F. Dittmyer a.k.a. Virginia Frances Dittmyer Wall for a Public Health Certificate;

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2. Taking such other and further action as deemed necessary and proper.

DATED: 9/17/04

Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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